DOCUMENT RESUME

ED 250 856 EC 170 891

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TITLE The Use of Published Language Tests with the Mentally Retarded: A National Survey.
PUB DATE May 79
NOTE 19p.; Paper presented at the Annual Meeting of the American Association of Mental Deficiency (Miami Beach, FL, May, 1979).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Language Tests; *Mental Retardation; Speech Therapy; Surveys; Testing Problems; Therapists

ABSTRACT

This study reports the results of a nationwide questionnaire survey of 204 speech and language clinicians from 65 facilities for mentally retarded individuals. Information was requested from clinicians about which language test they used with the mentally retarded population, why they used these tests, and how often they used them. Residential and non-residential facilities reported similar purchasing patterns of language tests. Only four tests comprised 53% of all language test administrations by the respondents during the 12 month period before the survey. Also, the predominant source of knowledge about tests was reported to be university training programs. The key issue raised by this report is why clinicians say they use particular tests. The results indicate that clinicians do not agree on the function of particular tests and some of their reasons appear of questionable validity. This report raises serious questions concerning language assessment of the mentally retarded which should prove useful for clinicians and trainers in university programs in the field of speech and language pathology. (Author/CL)

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THE USE OF PUBLISHED LANGUAGE TESTS WITH THE MENTALLY RETARDED:

A NATIONAL SURVEY

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Presented at the annual convention of the American Association of Mental Deficiency, May, 1979, Miami Beach, Florida.

EC170891

ABSTRACT

This study reports the results of a nationwide questionnaire survey of speech and language clinicians working with mentally retarded individuals. Information was requested from clinicians working at one hundred facilities, both residential and non-residential, as to which language test they use with the mentally retarded population, why they use these tests, and how often they are used. Since there are numerous published language tests and scales available with more being developed all of the time, and in the light of the attention being focused on programming of the mentally retarded, language assessment procedures become a critical issue. Two hundred and four clinicians responded from 65 facilities. Residential and non-residential facilities reported similar purchasing patterns of language tests. Only four tests comprised 53% of all language test administrations by the respondents during the twelve month period before the survey. Also, the predominant source of test learning is in university training programs. The key issue raised by this report is why clinicians say they use particular tests. The results indicate that clinicians do not agree on the function of particular tests and some of their reasons appear of questionable validity. This report raises serious questions concerning language assessment of the mentally retarded which should prove useful for clinicians and trainers in university programs in the field of speech and language pathology.

There are currently available to the speech and language clinician numerous published language tests and scales with more being developed all of the time. At the 1978 and 1979 ASHA Annual Conventions[1,2], over 30 new language tests and scales were introduced.* With so many new assessment instruments being developed and dozens of tests already available to measure language functioning, it is of importance to acquire additional information concerning clinicians' use of language test instruments.

A new test of language functioning may be devised to 1) measure a dimension of language functioning that no other existing test addresses, 2) measures dimensions of language functioning already addresed in an existing test, but is more appropriate to a particular segment of the population, 3) measures dimensions of language functioning already addressed in an existing test, but adds efficiency due to easier test administration and/or reduction in time of test administration, and 4) measures what is already addressed in an existing test, but produces more valid results.

One large segment of the communicatively disordered population which exhibits language deficits are mentally retarded individuals. Due to federal and state legislation, there has been a large increase in speech and language services provided for this population. Knowledge concerning language assessment and programming of the mentally retarded population is limited due to its being a relatively new area of interest in the field of speech and language pathology. This study was designed to ascertain information from practicing speech and language clinicians as to which language tests they use with the mentally retarded population, why they use these tests, and how often they are used.

In the literature[3,4,5] and throughout university training programs[6], clinicians are advised as to why and how to use published tests of language functioning. There is also a significant body of literature which provides warnings to clinicians about the use of language tests[7,8,9,10]. However, until now there had not been any information on how clinicians are actually using language tests. Due to the burgeoning number of language tests being developed, we felt it necessary to find out which tests are actually being used, why they are used, and how often they are

* This figure does not include presentations that were made concerning modifications of existing language tests, language tests developed for the hearing impaired and aphasic populations.

used by clinicians working with the mentally retarded population. All of these questions are relevant to the issue of language assessment of the mentally retarded population. A compilation and analysis of this data would generate issues for university training programs, continuing education programs, and job related pre-service and in-service training for practicing speech and language clinicians.

METHOD

A survey questionnaire was designed as the mechanism by which to secure the desired information. This section addresses development of the questionnaire packet, subjects surveyed, and procedures used.

Questionnaire Survey Packet

Each packet included an explanatory letter, copies of the questionnaire, a test inventory checklist, and a self-addressed, stamped envelope. The letter accompanying the questionnarie described the general purpose of the survey and assured confidentiality. It provided some instructions as to completion of the questionnaire. The self-addressed, stamped envelope was included for ease of mailing on the part of the responding clinicians.

Each facility was asked to fill out the test inventory checklist. Several blank lines were included at the bottom to allow entry of language tests not listed. Each clinician at the facility was asked to fill out a questionnaire. The first item, asked them to list all of the published language tests and scales they had administered during the past 12 months. A grid form was provided on the questionnaire for ease of response.

The second, third, and fourth questionnaire items referred back to the responses on the first item. The second question asked them to indicate from eight choices the principle place where they learned to administer and analyze each test they listed. The third question asked them to indicate, from eight choices, the principle reason why they give each test they listed. The fourth question asked them to estimate the total number of times they had administered each test or scale during the past 12 months. On the back of the questionnaire, each clinician was requested to fill in demographic information such as, the year they gra-

duated, degree received, population size of the facility, number of years they had been working with the mentally retarded and the state where they received their degree.

Before the questionnaires were mailed out in October, 1978, several clinicians completed questionnaires as a pilot run. Any necessary revisions needed for clarity were made prior to mailing.

Subjects

A survey questionnaire packet was mailed to facilities which serve the mentally retarded, two per state, one residential facility and one nonresidential facility. These facilities were chosen randomly within each state from a master list compiled from several sources[11,12,13]. Community clinics and facilities which serve various types of handicapped were excluded from this survey. The packets mailed to the facilities asked that all of the speech and language clinicians fill out a questionnaire.

Procedures

No follow up of second mailings were needed, as at the end of a two month period following the mailing, 68 of the 100 facilities had responded. Three of the 68 facilities indicated that they did not currently have a speech and language clinician on staff.

RESULTS

Demographic Information

Of the 65 facilities from which clinicians responded, 37 were residential and 28 were nonresidential. A total of 204 clinicians filled out questionnaires, 110 from residential and 94 from nonresidential facilities. Eighty percent of the clinicians had masters degrees. More than half of them (53%), had been working as speech and language clinicians for less than four years.

Test Purchased

Of key interest to clinicians, university trainers, and test developers is which test and scales of language functioning are the most commonly purchased by clinicians working with the mentally retarded (See Table 1). The purchasing patterns of tests did not directly correspond to the frequency at the which the tests were used (See Table 3). Among

the first ten tests listed, there was only one major difference in purchasing patterns between residential and nonresidential facilities. The Vineland Social Maturity Scale had been purchased by 68% of the residential and 43% of the nonresidential. Due to the current trend toward deinstitutionalization and legislation mandating local school districts to at least partially absorb the responsibility for the education of the severely handicapped population, the difference in purchasing patterns may widen as differences in abilities of the populations served at residential and nonresidential become more distinct.

Usage of Tests

The clinicians in the survey listed over 70 titles of published language tests and scales that they had used during the 12 months before the survey. Table 2 indicates the percentage of clinicians who used each test at least once during the survey period. Eighty-eight percent had given the Peabody Picture Vocabulary Test at least once during the 12 month period. The Test for Auditory Comprehension of Language was given by 68% of the clinicans and the Illinois Test of Psycholinguistic Abilities was administered by 53%.

Table 3 displays the prevalence of language test administrations by clinicians. During the one year period covered by the survey, the mean number of language test administrations was 132. Nonresidential clinicians administered more language tests (149) than residential clinicians (119). Although the clinicians used more than 70 different tests during the survey period, four tests, The Peabody Picture Vocabulary Test (24%), Test for Auditory Comprehension of Language (13%), Preschool Language Scale (9%), and the Verbal Language Development Scale (7%), comprised 53% of all language test administrations given to mentally retarded individuals by clinicians in the survey sample.

Training in Test Administration and Usage

Because new tests are continually being developed, it may be useful to know where clinicians learn about tests. Of the total number of clinicians responding to the survey, the predominant source of test learning is the university training program. The second most prevalent source of test learning is from the test manual and the third most prevalent source is learning from another practicing professional. Textbooks,

workshops, conventions, and journal articles were rarely reported as being the source of information concerning test administration and interpretation.

Decisions Made From Language Tests

The most significant issue addressed by this survey is the decisions made based on the results obtained from the administration of tests of language functioning. Each surveyed clinician was asked to indicate, for each test they listed, the principle reason he usually administers each particular test. The questionnaire item yielding the information provided eight multiple choice responses. This was felt by the authors to be a necessity due to the wide variety of responses which clinicians could have provided to an open-ended question format.

It is evident that there are marked differences as to the reasons particular language tests are administered (See Table 4). Following are a few examples of reported reasons clinicians administer particular language tests, which may be of questionable validity in light of the tests' construction and scope. The percentage refers to the number of clinicians who chose that response.

Item 1: Peabody Picture Vocabulary Test

14% Identify areas of language deficits

6% Identify deficits in language elements

Item 2: Northwestern Syntax Screening Test

35% Identify areas of language deficits

33% Identify deficits in language elements

Item 3: Receptive-Expressive Emergent Language Scale (REEL)

9% Identify areas of language deficits

5% Identify deficits in language elements

Item 4: Carrow Elicited Language Inventory

5% Ascertain if a language delay exists

DISCUSSION

It is not the intention of this article to judge the proper use of tests of language functioning, however, it is significant to note that clinicians make different decisions based on the information yielded from any one particular test. Generally, test authors will state the

purpose of the test in the manual, however, according to the survey results, clinicians are not consistent in the usage of test results. This is readily noticable from the survey in the case of the Peabody Picture Vocabulary Test (See Tables 2, 3, 4). It appears that more information is needed on decision making based on diagnostic language test results. An in-depth study focusing on any one of the more commonly used test would provide useful information. It would also be useful to compare the results of this survey to information gathered from the clinicians who work in other types of facilities.

Some general information about the use of language tests can be inferred from the results of this survey. It can be noted that although a particular test, such as the Illinois Test of Psycholinguistic Abilities, is purchased by most facilities and used by many clinicians, they actually administer this test very rarely. It is also evident that most clinicians gain their knowledge of language tests in university training programs. Clinic administrators, therefore, must be prepared to provide in-service training on new developments in diagnostic language testing. Most of the clinicans who responded to the survey, work in or adjacent to the state in which they attended college, therefore, fellow professionals generally have received similar exposure to language test instruments. This may limit the extent of on-the-job information sharing in regards to language testing. Staff from varied university programs can more easily supplement each other's knowledge in the area of language testing, yielding a broader reservoir of knowledge.

CONCLUSION

Language testing may serve several purposes, such as identifying if a language delay exists, identifying deficit skill areas, identifying deficits in language elements, and measuring progress. Assessment is the basis for language programming, and any attempt at remediation will be ineffective when based on invalid or unreliable information. Language clinicians need extensive training in assessment procedures at the university level. On-the-job supervisors should provide pre-service and in-service training for clinicians in order to increase competency skills in language assessment. It is the professional and ethical

responsibility of each clinician to upgrade his assessment and diagnostic skills so that remediation efforts are maximally beneficial.

This survey did not address nonstandardized approaches to language assessment[14]. It would be useful to know how nonstandardized assessments are used in relation to standardized measures. Many of the clinicians who responded to this survey commented that they were disappointed that there are so few useful language tests for the severely language delayed, mentally retarded.

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Table 1, Language Tests Purchased

Test	Total (%)N=65	Residential (%)N=37	Nonresidential (%) N=28
1. Peabody Picture Vocabulary Test	98	97	100
2. Illinois Test of Psycholinguistic Abilities	88	89	86
3. Northwestern Syntax Screening Test	68	65	71
4. Test for Auditory Comprehension of Language	65	65	64
5. Utah Test of Language Development	65	68	61
6. Receptive-Expressive Emergent Language Scale	62	68	54
7. Vineland Social Maturity Scale	57	68	43
8. Assessment of Children's Language Comprehension	55	57	54
9. Boehm Test of Basic Concepts	54	49	61
10. Denver Developmental Screening Test	52	46	61
11. Preschool Language Scale	49	46	54
12. Verbal Language Development Scale	46	57	32
13. Developmental Sentence Scoring/Developmental Sentence Types	45	38	54
14. Carrow Elicited Language Inventory	35	27	46
15. Houston Test of Language Development	31	35	25
16. Sequenced Inventory of Communication Disorders	28	22	36
17. Basic Concept Inventory	22	14	32
18. Ammons Full Range Picture Vocabulary Test	20	19	21
19. Environmental Language Inventory	20	16	25

20.	Hiskey-Nebraska Test of Learning Aptitude	20	16	25
21.	Vocabulary Comprehension Scale	17	19	14
22.	Miller-Yoder Test of Grammatical Comprehension	15	16	14
23.	Parson's Language Sample	14	14	14
24.	Michigan Picture Language Inventory	9	5	14
25.	Test of Language Development	7	3	14

Table 2, Percentage of Clinicians Who Used Each Language Test

N=204

	Test	Percentage
1.	Peabody Picture Vocabulary Test	88
2.	Test for Auditory Comprehension of Language	68
3.	Illinois Test of Pscyholinguistic Abilities	53
4.	Utah Test of Language Development	33
5.	Preschool Language Scale	36
6.	Assessment of Children's Language Comprehension	33
7.	Northwestern Syntax Screening Test	30
8.	Receptive-Expressive Emrgent Language Scale	27
9.	Carrow Elicited Language Inventory	21
10.	Developmental Sentence Scoring/Developmental Sentence Types	18
11.	Verbal Language Development Scale	17
12.	Sequenced Inventory of Communication Disorders	15
13.	Communication Evaluation Chart	8
14.	Houston Test of Language Development	5
15.	Miller-Yoder Test of Grammatical Construction	5

Table 3, Prevalence of Language

Test Administrations.

Test	Total N=27,019 (%)	Residential N=13,054 (%)	Nonresidential N=13,965 (%)
1. Peabody Picture Vocabulary Test	24	25	22
2. Test for Auditory Comprehension of Language	13	12	13
3. Preschool Language Scale	9	7	11
4. Verbal Language Development Scale	7	14	1
5. Utah Test of Language Development	7	7	6
6. Receptive-Expressive Emergent Language Scale	6	6	5
7. Illinois Test of Psycholinguistic Abilities	6	5	6
8. Assessment of Children's Language Comprehension	4	4	3
9. Northwestern Syntax Screening Test	4	2	4
10. Carrow Elicited Language Inventory	3	1	4
11. Boehm Test of Basic Concepts	3	1	4
12. Developmental Sentence Scoring/Developmental Sentence Types	2	1	3
13. Sequenced Inventory of Communication Disorders	1	1	3
14. Gesell Full Range Action/ Agent Vocabulary Test	1	0	2
15. Miller-Yoder Test of Grammatical Construction	1	2	1

Table 4

Principle Reason Clinicians Administer Language Tests to their Mentally Retarded Populations

	Peabody Picture Vocabulary Test	Test for Auditory Comprehension of language	Illinois Test of Psycholinguistic Abilities	Utah Test of Language Development	Preschool Language Scale	Assessment of Children's Comprehension of Language	Northwestern Syntax Screening Test	Receptive-Expressive Emergent Language	Carrow Elicited Language Inventory	Developmental Sentence Scoring/ Developmental Sentence Type
A. Ascertain if a language delay exists.	28	10	2	29	20	9	22	22	5	0
B. Identify areas of language deficits.	14	43	68	36	45	26	35	19	32	20
C. Identify deficits in language elements.	6	44	17	9	9	54	33	5	54	54
D. Determine degree of language delay.	31	3	6	17	14	9	5	43	10	17
E. Measure progress.	9	0	1	4	0	2	0	0	0	9
F. Determine prognosis	1	0	0	0	0	0	0	2	0	0
G. Determine pr9gram eligibility of placement.	2	0	5	3	12	0	5	5	0	0
H. None of the above, but required as part of assessment.	8	0	1	3	0	0	0	3	0	0
Percentage of Clinicians Responding	84	64	50	33	33	31	29	27	20	17

APPENDIX

(Many of the clinicians who responded to the survey took the opportunity ot write comments in the section provided for that. Below is a sampling of some of their comments concerning language testing with the mentally retarded population.)

1. Most language test presently available are inappropriate for assessment of institutionalized MR population due to level of functioning, unfamiliarity with test items, abstract pictures,, and other physical impairments accompanying MR.

2. I do not use a standardized (language) test. I have not found any particular one to be of much help (in this setting).

3. I work with (mentally retarded) adults and many of the published testing material is not applicable for several reasons: 1) the norms for adults don't exist, 2) I don't feel that the information gained by language tests really help in planning for adult needs as it does with children. I hope to see tests geared for adult retardates in the near future.

4. Most scales tend to agree on receptive language development. But expressively, it is more difficult to evaluate non-verbal individual's use of pointing, gesture, grunts, etc. as few scales deal with such things.

5. Approximately 1/3 to 1/2 of the population at this facility has a functional language level below the basal age on most published language tests. Those with lower scores usually provide little useful information at that level.

6. ...there is a need for more objective methods of determining which (mentally retarded) clients should be placed in speech therapy... There is also a need for colleges and universities to provide with MR

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clients and in diagnosing and doing therapy with them.

7. This is an interesting survey...I realized that you are trying to isolate your topic, but the results from articulation testing can be extremely revealing when looking at the total language problem. Oh well...that's my opinion.